Correspondence

Asthma Deaths

TO THE EDITOR: The concern expressed by Dr Sharma on the rising incidence of death from asthma is a real issue.[1] In his article in the November 1989 issue, the author also advocated using aerosolized corticosteroids (AC) before a trial of cromolyn sodium is attempted. I find the reasoning behind this quite puzzling. Granted that ACs are relatively safe and usually more effective than cromolyn, but they are not entirely free of side effects. Whereas ACs are not infrequently associated with oropharyngeal candidiasis and myopathy of the laryngeal muscles, cromolyn is practically free of side effects.

Even more disturbing, the author apparently overlooked the role of antiallergy management in his recommendations, even though he alluded to the fact that those who are allergic "are at an increased risk for acute severe attacks of asthma." One would reason that if allergens do play such an important role in the severe attacks, some efforts should be made to identify these allergens. As I see it, the major schism between many pulmonologists and allergists is that the former mostly neglect the roles of avoiding allergens (especially pets, house dust mites, etc) and of immunotherapy in antiasthma treatment. The rising rate of asthma deaths in the face of ever more potent antiasthma drugs would seem to highlight the fact that this battle is unlikely to be won by pharmaceutical agents alone.

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Thymic Carcinoid and Multiple Endocrine Neoplasia

TO THE EDITOR: I read with interest Venkatesh and Samaan's description of the University of Texas MD Anderson experience with six cases of thymic carcinoid tumor.[1] I am treating a similar case, and the patient is also from Texas. Because such cases are unusual and can present difficult and prolonged management problems, it may be useful to add my experience to the literature.

Report of a Case

A previously healthy 35-year-old man had a parathyroid adenoma resected in 1983. Chest pain subsequently developed, and a 6- by 5- by 4-cm superior mediastinal thymic carcinoid was removed during a left parasternotomy in March 1985. His serum calcium level was 2.99 mmol per liter (12.0 mg per dl), serum phosphorus 0.61 mmol per liter (1.9 mg per dl), the C-terminal parathyroid hormone (PTH) was 268.5 pmol per liter (normal 45.3 to 195.9), and the N-terminal PTH was 168.5 pmol per liter (24.2 to 66.3) at American BioScience Laboratories; a blood serotonin level was 130.4 nmol per liter (normal 283.5 to 1,134). Postoperative calcium levels remained elevated, and he received irradiation to the mediastinum. Four months later, right supraclavicular lymphadenopathy developed and was excised. Both the mediastinal tumor and the supraclavicular mass were interpreted as carcinoid, composed of small, round cells with brightly eosinophilic cytoplasm and small, round nuclei. Immunoperoxidase staining for calcitonin was negative. Notable electron-microscopic features included the presence of multiple neurosecretory granules with a dense core and halo, numerous free ribosomes, and no microvilli. The supraclavicular mass included lymph nodes and tumor extending into paralymphatic fat and connective tissue.

Both the serum calcium and PTH levels remained mildly elevated. Supraclavicular radiation therapy and fluorouracil and streptozocin chemotherapy for one year were given without change in the serum calcium or PTH values. A new right supraclavicular mass was excised in April 1986 and found to be fibrotic tissue without tumor. He was observed off therapy until recurrent pancreatitis with hypercalcemia prompted a neck exploration and the removal of a parathyroid adenoma in June 1988. The serum calcium levels returned to normal temporarily, but the pancreatitis recurred. Pulmonary nodules were discovered and removed in September 1989 and found to be recurrent carcinoid. He is now being treated with systemic infusional fluorouracil. Parathyroid hormone and serum calcium levels remain elevated, serum electrolytes are normal, and there have been no symptoms of flushing or diarrhea.

Discussion

Young age, an association with parathyroid tumors, male sex, prolonged survival, and the absence of the "carcinoid syndrome" are typical features seen in this and other patients with thymic carcinoid. The propensity for local and regional recurrences of the carcinoid, and our inability to definitively treat these patients with chemotherapy,[2] suggests that initial, aggressive surgical therapy, preferably through a sternal splitting incision, with complete removal of the thymus, should be carried out.

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Iatrogenic Illness

TO THE EDITOR: I just had the opportunity to read the medical staff conference on iatrogenic illness in the November 1989 issue.[1]

The comments and observations made by Dr Tierney are all important, but I wish to point out a major omission. Call it the sixth cause of iatrogenic illness, or maybe better yet, it should be called the first or second.

The medical profession has created illness where once it did not exist. We take persons with somatic complaints for which there are no objective findings and for which there is not a true organic lesion. A good history will reveal that this class of disease is stress-induced. The physician may recog-

nize the psychogenic component for the illness but elects to disregard it and treat it as a straightforward organic illness, thereby supporting the patient's displacement of stress onto a somatic target. Since the stress is not dealt with, and since the organic illness is supported, the complaints continue and intensify over time.

There are notable examples of such illness—peptic ulcer disease is a good one. This is a stress-related disease that most physicians treat organically. Globus hystericus is another example of a disease that is invariably stress-induced and that the unsuspecting physician worsens by ordering barium swallows, esophageal manometrics, endoscopies, and follow-up appointments for the sole purpose of physical examination. More flagrant examples are the myofascial pain syndromes. Temporomandibular joint pain is an excellent example of such an illness.

The frequency of iatrogenic illness is debated. Those unskilled at diagnosis will tell you it is infrequent, if not altogether nonexistent. Those in primary care, sensitive to such problems, will tell you that 50% of what they see is stress-related, and by inference, those same patients, in the hands of someone not sensitive to psychogenic illness, will be dealing with 50% iatrogenic illness—the irony, of course, is that the illnesses are their iatrony.

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The War on Drugs

To THE EDITOR: What is "the war on drugs"? We think it is a fight against

- noncriminal (except that they use illegal drugs) addicts who buy the drugs;
- noncriminal nonaddicts who buy the drugs;
- organized crime (suppliers); and
- criminals who steal to continue their habit (users).

We could eliminate all but one of these adversaries—the "noncriminal" addicts—simply by decriminalizing illegal drugs. As a profession and as a society we do need to fight addiction, in the sense of helping addicts if we can. If drugs were decriminalized, we would still have that battle to wage, as we do today, but probably with not many more enemies.

Well-known political figures, such as George Schultz, are seeing the wisdom of decriminalization. The war on drugs is a war we cannot win, any more than we could win the fight against alcohol during Prohibition. If the money spent on the war against drugs were diverted to treatment for addiction, the medical profession would profit. More important, addicts and society as a whole would be a lot better off. We think it is time the medical profession took a medical and sensible stand on this subject.

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The Eye of the Beholder

To THE EDITOR: This is in response to the letter by Dr Arthur Vall-Spinosa in the December 1989 issue.[1]

"Glowing accounts" are somewhat in the eye of the beholder. I am very enthusiastic about a system in the United States that would permit the entire population to have access to decent medical care. Whether the Canadian health care system is the model we should emulate is open to question. There are clearly problems with the Canadian system, and transplantation to the United States might be very difficult.

Incidentally, there are not "tight limits" on the number of physicians in Canada. This was tried in British Columbia but thrown out in the courts. Certainly, the malpractice specter contributes to the cost of medicine in the United States, but it is not the major obstacle to a cost-effective national health care program.

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Tryptophan Use and Fasciitis

To THE EDITOR: Tryptophan, available both through health food stores and in pharmacies as a soporific, has recently been associated with eosinophilia and myalgias.[1] We report three cases and the biopsy findings of an eosinophilic fasciitis-like process associated with inflammatory myopathy.

Report of Cases

The patient, a 52-year-old housewife, used 1,500 to 3,000 mg of tryptophan nightly for five years and only recently developed myalgia of her upper and lower extremities. Her creatine kinase level was normal and a complete blood count showed a total leukocyte count of 26.0×10^9 per liter with 0.45 eosinophils. A biopsy specimen of gastrocnemius muscle showed macrophages, lymphocytes, and eosinophils invading the perimysium and endomysium (Figure 1). The muscle fibers themselves appeared relatively normal, but stains for adenosine triphosphatase showed fiber type grouping.

The second patient, a 29-year-old woman, had been taking 1,500 mg of tryptophan two to three times a week to help her sleep. Progressively worsening myalgias developed, associated with a red rash and a leukocyte count of 17.6×10^9 per liter with 0.56 eosinophils. A biopsy specimen of right gastrocnemius muscle showed an inflammatory infiltrate composed of a mixture of lymphocytes, macrophages, eosinophils, and plasma cells in the fascia with spillage into the perimysium and adipose tissue. The perineurium of several nerves in the specimen showed prominent inflammatory infiltrates. Staining for adenosine triphosphatase disclosed fiber type II predominance.

The third case is most intriguing as the patient presented in 1985 with a livedo-type rash on her anterior thighs and complaints of diffuse myalgia associated with low-grade fever and 0.3 peripheral eosinophilia. A creatine kinase level was normal. She had been taking as much as 3,000 mg of tryptophan each night to help her sleep. A biopsy specimen of right gastrocnemius at that time showed a scattered in-